



**California Department of Mental Health (DMH)
Performance Measurement Advisory Committee (P-MAC)
Meeting Minutes
September 9, 2005
Sheraton Grand Hotel, Sacramento**

Committee Attendance:

Chair: Stephanie Oprendek

Co-Leader: Tom Trabin

Members: Neal Adams, Ann Arneill-Py, John Campbell, Karen Hart, Tracy Herbert, Laurie Lindamer, Mark Morrison, Ethan Nebelkopf, Ralph Nelson, Jr., ThuHien Nguyen, Joyce Ott-Havenner, Nancy Peña, David Pilon, Ryan Quist, Neal Sternberg, Nancy Thomas, Alice Washington, Bonnie T. Zima. (Committee members Maria Aranda, Cristina Magaña were not present.)

MHSOAC Liason: Gary Jaeger

Introductions / Welcome Remarks and Committee Overview

The Chair and Co-Leader were introduced.

Each P-MAC member introduced him/herself and gave a brief background of the experience that he/she will bring to the Committee. Committee members were asked to provide a brief written biography to DMH staff for posting to the DMH website. It was noted that there is a balance in the skills/experience of the members that consists of the different age groups served by mental health, cultural competence backgrounds, consumer / family member perspectives, information technology, clinical and research, etc.

The Co-Leader explained that MHSA presents a historic opportunity. Outcomes are an integral part of the Mental Health Services Act and the work that will be done by the Committee members is central to the success of the Act. Nationally, people are tracking the impact the Act has on California's Mental Health System.

The Co-Leader explained to the Committee that initial performance outcome measures based on the AB2034 model will be needed January 1, 2006, since some counties have communicated that they are likely to be ready to begin MHSA services and supports as of January 2006. As a result, Performance Outcomes and Quality Improvement (POQI) staff have developed a set of data elements for the Committee's review in the afternoon session, referred to as Key-Event Tracking, that were based on the AB2034 Integrated Services for Homeless Adults program.

The Rules for Discussion are as follows:

1. Members must respect each other. There may be disagreements about an issue, but it is not personal.
2. No interrupting; let people have their say.
3. Members may not send a substitute if they are unable to attend a meeting.
4. Explain acronyms, as some Members are not familiar with what the acronyms represent.
5. Committee members must raise their hands if they wish to make a comment. The Co-Leader will keep track of the hands and, when appropriate, will call on Members in order.
6. Voting categories will range from 'strongly support' to 'uncertain but can live with the proposal' to 'definitely not, this is a show-stopper.' If the majority vote carries an issue, but a committee member(s) has considerable objection, that objection will be documented.
7. Cellular phones and/or pagers must be placed on silent or vibrate.

The short-term goal of the Committee is to focus on the Key-Event Tracking (KET) data elements. Committee members will be tasked with reviewing the draft forms and providing comments and feedback to DMH.

The Co-Leader provided the following review on criteria for selecting outcome measures, including meaningfulness, feasibility, and accuracy.

The Committee is designed to meet long term. Though there are short-term tasks (i.e., reviewing the KET), there are long-term goals. The Committee should plan to meet once a month either by meeting in person or by conference call. Sometimes members may need to meet more than once a month.

DMH Measurement Approaches, Tasks, Timelines – Stephanie Oprendek

The role of the Committee is to provide advice and guidance to DMH. However, some recommendations may not get adopted. A record will be kept of all recommendations of the Committee. The Committee is not just for the Act, it is also to meet the requirement stipulated in Realignment Legislation. In this regard, the responsibilities of the Committee go beyond the MHSA per se, and will evaluate the California mental health system as a whole. Performance measurement generally, and MHSA performance measurement in particular, are not separate. If we think about the MHSA as a catalyst for system transformation, and that we need performance measurement for system transformation, then we must address the mental health system as a whole when designing performance measures.

There are ties between the P-MAC and the Mental Health Services Oversight and Accountability Commission, the California Mental Health Planning Council, and the State Quality Improvement Committee (SQIC). SQIC and P-MAC will complement each other in the development of performance measures and use of

resulting data for quality improvement. The CMHPC also has the authority to review and approve performance measures. Dr. Jaeger, who is the liaison between the MHSA Oversight and Accountability Commission and the P-MAC, will report the P-MAC input/discussion to the MHSAOAC and bring information from the MHSAOAC to the P-MAC, so that we are working toward common goals.

Several important goals of the Act were presented and discussed:

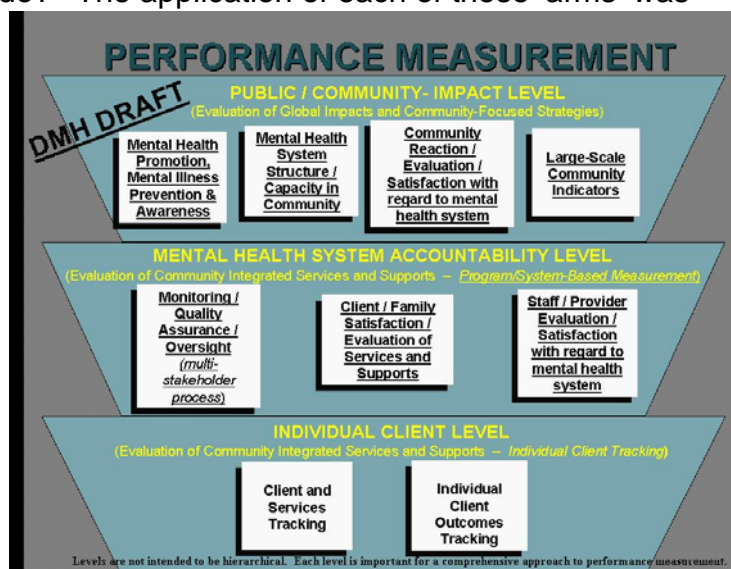
1. Decreasing homelessness
2. Reducing child out-of-home placements
3. Reducing criminal justice system involvement
4. Leveraging MHSA dollars – seed money for housing, SSI, MediCal, etc...
5. PREVENTION: Efforts that ultimately will reduce the need for mental health services.

The goal is a shift from a distribution of 80% service delivery and 20% prevention to the reverse: 20% service delivery, 80% prevention.

When responding to the goals/impact, some Committee members felt that the language used was negative and that it should be changed to be positive to reflect the spirit of transformation. Some members also felt that there should be an additional category added for 'increase in income.' It was noted that the list presented was not exhaustive, and that there were many more areas of interest for outcomes measurement.

The overall goal of the Committee is to determine how best to measure outcomes in a quantifiable way – how do we count / measure outcomes in order to demonstrate the value of mental health services and ensure continued funding. Oftentimes, when DMH requests feedback from different groups on specific outcomes measurement strategies, the response is one of 'vision'. The purpose of the Committee is to address the vision by successfully defining outcome indicators that reflect the desired vision, and by developing specific, concrete outcomes measurement strategies.

There are basically two arms of accountability: 'Outcomes' and 'Are we doing what we said we were going to do?' The application of each of these 'arms' was illustrated in the Performance Measurement tri-level model (shown to the right) and in the 'Draft Preliminary Discussion of the Performance Measurement Design' document, which was emailed to each Member prior to this meeting. This tri-level design is not meant to be hierarchical. Its purpose is to be used as a framework to



assist the Committee in designing methods of measurement for each component (e.g., one approach to measuring mental health prevention and awareness at the community level can be to implement anti-stigma campaigns and then measure community attitudes towards mental health).

For the purposes of the KET, Members are asked to focus on the 'Individual Client Level, Individual Client Outcomes Tracking' section of the tri-level model and how changes in key areas can be captured over time. The KET is a small piece of the evaluation strategies that the Committee will be developing. For now, Members are asked to review the forms presented in the afternoon session. It was also noted that some data elements may not be seen on the KET forms and there will be other, more appropriate methods to capture certain types of information, rather than KET. Administrative data sets (e.g., the Client and Services Information (CSI) System), survey-based assessments, focus groups, etc., can also be used to gather additional information.

It is extremely important to note that key event tracking is not the only method to collect information. Over time, many methods and measures will be introduced for the committee's consideration, which will be necessary for the full service partnerships evaluations as well as for performance measurement implementations beyond the full service partnerships, e.g., program/system evaluation and community impact.

For now, the Committee is on a strict timeline. As was mentioned, on January 1, 2006, the Full Service Partners are going to start receiving services under the Act; therefore, a data collection methodology must be available at that time. DMH acknowledges that there are other important data elements that need to be captured, but for the immediate January 1 needs, the plans are to build off of what has been established with the AB2034 methodology. The committee will then immediately embark on addressing important recovery, cultural competency, and other domains with respect to the measurement methodologies that are most appropriate to address them. Once the January 1, 2006, deadline responsibilities have been met, the Committee will have opportunities to brainstorm and be creative, not only in developing data elements, but also in developing strategies for using technology to support outcomes measurement.

Key Event Tracking Example: AB 2034 – Dave Pilon

The Integrated Services for Homeless Adults program initially began in 1999 under AB34 and in 2000 became AB2034. Though it involves a comprehensive data collection effort, the program has been structured with a low client to staff ratio, and the assessment methods were built in from the beginning in order to allow successful data collection and client tracking.

Dave reviewed the types of outcome domains typically measured in mental health programs, which consist of:

- clinical status (i.e., symptomatology)
- functional status (e.g., ability to perform age appropriate activities)

- quality of life from the client perspective
- adverse events / negative outcomes (e.g., hospitalization)
- satisfaction (i.e., consumer perception of care)

He further explained that AB 34 took the approach of measuring what he called “objective quality of life outcomes,” which consist of the service recipient’s status in such domains as residential, employment, legal, etc., as well as their status in domains that are considered “adverse events” (e.g., hospitalization, incarceration, etc.).

The original AB34 outcomes language required that programs be designed to enable recipients to:

1. live in the most independent, least restrictive housing feasible in the local community.
2. engage in the highest level of work or productive activity appropriate to their abilities and experience.
3. create and maintain a support system consisting of friends, family, and participation in community activities.
4. access an appropriate level of academic education or vocational training.
5. obtain an adequate income.
6. self-manage their illness and exert as much control as possible over both the day-to-day and long-term decisions which affect their lives.
7. access necessary physical health care and maintain the best possible physical health.
8. reduce or eliminate antisocial or criminal behavior and thereby reduce or eliminate their contact with the criminal justice system.
9. reduce or eliminate the distress caused by the symptoms of mental illness.
10. have freedom from dangerous addictive substances.

Although these outcomes are rank ordered, the presenter noted that #6 might benefit from being changed slightly and moved to the top of the list since everything flows from one’s ability to take control of one’s life. The presenter also mentioned that rather than ‘having freedom from dangerous addictive substances,’ it may be better to take a harm reduction approach to substance abuse. It was also noted that reducing symptoms should be done in context of all of the above.

AB2034 data are captured in real-time by some counties. First, staff work collaboratively with clients to document data on a history of several status domains for the year prior to the date of enrollment. From that point onward, all changes in the status domains are tracked and entered into a data system. At

any given time, in order to provide the most appropriate services and supports, staff know the status of the client.

Members of the Committee questioned the reliability of the client's recall on their history for the prior year. It was stated that hospitalization data was matched with data collected by DMH and the results indicated that the data were quite reliable. There may be some evidence, however, that clients report more previous employment than is the reality.

Committee members also asked if clients underreported jail days. It was stated that a jail history could be associated with the receipt of services, so jail days may not be under-reported in such cases.

It was also explained that the data for the AB2034 program were annualized, meaning that a correction was made on the average length of enrollment in the post-enrollment period compared to the 12-month history data. The average length of client enrollment was greater than two years.

Ethical and practical issues have not allowed for a control group for the AB2034 evaluation. A Committee member mentioned that the Mentally Ill Offender Crime Reduction Grant program did include a control group, where the experimental groups showed more improvement than the control group.

Furthermore, it was explained that AB2034 included severe and persistently mentally ill individuals over the age of 18 who were outreached via jail and homeless programs. Participation in the program was voluntary.

Committee members stated that AB2034 involved a captive audience and staff knew where to find people and could track them. It was mentioned that AB2034 includes a relatively small caseload for staff and added that the Full Service Partnerships of the Act will also involve a small caseload.

Committee members asked if there was any evidence of a reduction in disparities. It was stated that, although such data are available, that analysis has yet to be conducted.

Committee members also asked if analyses had been performed to look at clients across all years. Several slides were shown of such analyses across each of the status domains, each showing positive outcomes.

Important considerations of the AB2034 program included:

- Data audits (staff at AB34/2034 constantly monitor the data)
- User-friendliness / usefulness
- System interoperability
- Domains that do not lend themselves easily to real time changes

More information regarding AB34 / AB2034 can be found on the Internet at www.ab34.org.

Several committee members who have been involved in the AB2034 data collection at counties mentioned that there has been flexibility in collection

methods and data elements for counties with respect to the AB2034 program. They reported that this flexibility is desirable for counties in order to increase the feasibility of, and reduce the redundancy of data collection. Members mentioned that although not all counties collect information exactly the same way the presenter presented the AB2034 data collection methodology, they are successful in reporting the required data.

**Presentation on Early Data Collection Strategies for Full Service Partnerships –
Stephanie Oprendeck, Traci Fujita, Brenda Golladay**

DMH staff gave a brief overview of the draft forms for the KET for Adults and Child/Youth clients, and demonstrated the DMH Web-Based Data Reporting System (WBDRS) on-line key entry screens for these forms. DMH staff noted that the paper versions of the forms are longer than the on-line key entry version. The paper forms would, most-likely, be used as worksheets to gather information from the client and calculate lengths of time. The on-line key entry version will simply provide space to input the final answer.

Based on the AB2034 program, two forms were presented for each age group: one to capture the 12-month history/baseline information and one to capture data when specific key events occur in the client's life. Each form included a brief demographic section, a Residential / Hospital / Incarceration section, Justice System Involvement, Emergency Room Utilization, and Education. In addition, the Adult forms included sections for Employment and Income. Though similar to the AB2034 data elements, the KET forms included some data element consolidation, as well as the addition of new data elements.

The Committee asked if counties would be permitted to change the forms and add questions. DMH staff replied that this would be acceptable as long as the required data elements were reported according to DMH specifications. Some concern was raised about the need for standardization and less flexibility across providers. The Committee also raised the issues that offering more flexibility may reduce redundant data collection at the local level. DMH staff agreed that reducing redundancy is important and that counties have traditionally wanted to collect additional data elements that may be meaningful at the local level. It was added that in order to accomplish some flexibility at the local level in terms of data collection while also having uniformity of data reported to the state, XML (extensible markup language) is being considered for data reporting and transfer between counties and the state.

The Committee expressed concern about the security / confidentiality of the WBDRS. DMH staff responded that the WBDRS was designed in accordance with HIPAA requirements and that special security features (e.g., hard password requirements, disabled back button, screen timeouts, encryption, etc.) were built into the design of the system.

The Committee also expressed concern about consent and, again, about reducing redundancy. Also, comments were made stressing the importance of prioritizing rapid feedback to the data collectors so that they would find their efforts to be meaningful. DMH staff responded that DMH wants to address these

issues. It is likely that with the MHSA funds, there will be more of an opportunity to develop more complex information systems in the future with reporting capabilities, and eventually progress towards an Electronic Mental Health Record (EHR) system that decreases data silos and redundancy.

The Committee also mentioned that there should also be measures related to recovery, cultural issues, etc. DMH staff reminded the Committee that the first task was to finalize the KET so that it could be implemented on January 1, 2006, and, once completed, the Committee can focus on developing creative approaches to target different outcome areas within their respective, appropriate, measurement methodologies (e.g., surveys and assessment tools, administrative data, interviews, review tools, focus groups, etc.).

Concern was again raised about the burden of data. Some Members felt that less data are better. One member suggested that a filter be applied when deciding on a data element: is it necessary in terms of the desired outcome?

The goal is not only to incorporate AB2034, but also to transform the system to demonstrate impact in a major way. For example, ask the client if he/she is at the poverty level, then implement an Evidence Based Practice (EBP) and then ask the individual the same question.

The Committee asked if clients in the AB2034 were able to provide their history (e.g., on the Residential section). The AB2034 forms are completed over a period of time as staff and clients developed a collaborative relationship – and that events and holidays were successfully used to help determine days spent in various living situations. It was mentioned by the Committee that it may be more difficult to track the Residential status of child/youth clients.

With respect to the KET forms, DMH staff asked the Committee if it is necessary to identify whether a change in Residential, Criminal Justice, and / or Emergency Room status was substance abuse and / or mental health related. During an extensive discussion, the Committee concluded that, although such attributions are important, collecting it on these particular status domains may not yield accurate data since it is often difficult to delineate between the two contributions. DMH staff mentioned that the CSI system is currently being revised and that a data element that captures dual diagnosis information is currently being proposed. It was decided to leave the “psychiatric/substance abuse” distinction in the Emergency Room Status for now while the physical health distinction is also considered.

A discussion also ensued that debated whether or not the categories ‘jail’ and ‘prison’ should be combined on the Residential status domain. It was determined that it should remain separate since each setting has a different associated cost, and may indicate different levels of severity.

For the next meeting, the Committee requested an overview of the other data collection efforts/plans (e.g., CSI, surveys, etc), so that the KET could be understood in the context of other data already collection and/or envisioned.

The Committee also reminded the group members that logistics need to be discussed. AB2034 required a lot of time, people and training and many counties will not be familiar with the rigors of the AB2034 program and therefore, implementation may be more difficult for some counties.

The Committee also requested that when the information on the forms are collected, that the client also has input into what is being recorded.

Open Forum Input - Stakeholders

Comments made during the open forum included the following:

- To ensure that public comments are well-focused and based upon accurate information, make the handouts available and have the PowerPoint Presentations posted to the DMH MHSA website.
- Pay attention to formulating the broad outcomes desired and not just the measures.
- Who is this all for? Need to make it clear from what perspective(s) you are looking at the data elements (e.g., state, consumer, provider, etc.).
- With respect to substance abuse, ask: "Was substance abuse a salient factor in the event change?"
- Tracking clients (e.g., key event tracking) is good because clients' lives are not static; they don't stay the same.
- Native American programs have not enjoyed statistical representation in analyses since they are often undercounted in the census. Native Americans are often included in the Hispanic category and not presented as a separate group in most studies. Report Native American as a separate category.
 - DMH staff noted that DMH collects and reports 'Native American' as a separate category.
- It is important to provide a feedback loop to all staff in mental health so they can appreciate what they are doing well and understand what might need improving.

Next Steps / Next Meeting Plans – Tom Trabin & Stephanie Oprendeck

Because the meeting ended before the KET forms could be finalized, Committee members were asked to volunteer to participate on conference calls to continue working on forms for each age group. The volunteers were as follows:

Child/Youth:

Nancy Pena
Bonnie Zima
Neal Sternberg

Transition Age Youth:

Neal Sternberg
Dave Pilon
Karen Hart

Adult:

Older Adult:

Dave Pilon
Alice Washington
Joyce Ott-Havener
Neal Adams
Thuhien Nguyen
Ralph Nelson

Ann Arniell-Py
John Campbell
Maria Aranda
Laurie Lindamer

DMH staff will arrange the conference calls and will send an email to all Committee members with the date / time of the calls, as well as any related materials, and other members were encouraged to participate if schedules permit.

Next meeting: The next meeting will be held on Monday, October 24, 2005 at the Sheraton Grand Hotel in Sacramento, California.